	Phone: 818-563-2120 Fax: 844-500-3843 or 818-563-2130

Patient Name:	Today's Date:
DOB SSN	Prescriber:
Home Phone Work/Other Phone	Phone Number Fax Number
Home Address	Address
Shipping Address (If different from home address)	Office Contact: Prefers: ☐ Fax ☐ Phone ☐ E-mail ____________________
Language Preference: ☐ English ☐ Spanish ☐ Other _________	Ship to: ☐ Home ☐ MDO NEED CLASS___________________

Rx: Xifaxan

TAPE PRESCRIPTION HERE PRIOR TO FAXING **OR** COMPLETE THE FOLLOWING:

☐ **Traveler's Diarrhea** One 200 mg tablet 3 times a day for 3 days **Qty:** __________ **Refill x** __________
☐ **Hepatic Encephalopathy** One 550 mg tablet 2 times a day **Qty:** __________ **Refill x** __________
☐ **IBS-D** One 550 mg tablet 3 times a day for 14 days. **Qty:** __________ **Refill x** __________

Physician Signature: ___________________________________ **DEA:** _____________________________________